BlueCross BlueShield of Texas

# Blue Cross Blue Shield Solution 4, a Multi-State Plan[SM]

**Blue Cross and Blue Shield of Texas** *(herein called "BCBSTX, We, Us, Our")*
Preferred Provider Plan providing Comprehensive Major Medical Coverage

**REQUIRED OUTLINE OF COVERAGE / WRITTEN DESCRIPTION**

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from BCBSTX.

This coverage is provided by Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company. This coverage provides preferred provider benefits.

**This information is intended only as a summary and should not be relied upon to determine coverage. The Policy of coverage contains a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of You, Your Physician or Professional Other Provider and Us. It is, therefore, important that You READ YOUR POLICY CAREFULLY!**

**Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.**

If the Policy is purchased through the Exchange, BCBSTX is not the agent for the Exchange and is not responsible for the Exchange. All information that You provide to the Exchange will be relied upon as accurate and complete. You must promptly notify the Exchange and BCBSTX of any changes to such information.

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health insurance policy's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care providers and particular Policy chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular Policy.

Please note that for Child-Only coverage no additional Dependents may be added to Your Policy.

Hereafter, Dependent child, child or children means a child who has been determined to be eligible for coverage, who is covered under the Policy and who is a natural child of the Subscriber, a stepchild, a legally adopted child of the Subscriber (including a child for whom the Subscriber is a party in a suit in which the adoption of the child is being sought), an eligible foster child under twenty-six (26) years of age, regardless of the presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. A grandchild must be dependent on the Subscriber for Federal income tax purposes at the time application for coverage to be eligible for coverage under the Policy.

## Toll-free Telephone Number

You can call our Individual Products Business Unit, Monday through Thursday from 9:00 a.m. to 5:00 p.m. and Friday 9:00 a.m. to 4:30 p.m. Central Time. The number is:

**1-888-697-0683 toll-free**
— Or —
for additional information, write to:

**Blue Cross and Blue Shield of Texas**
**Individual Products Business Unit**
**P. O. Box 3236**
**Naperville, Illinois 60566-7236**

## What Is the Difference Between a Network Provider and Out-of-Network Provider?

**A Network Provider is**:

- Any Provider who has executed a managed care agreement with BCBSTX; or
- Any other Provider located outside the state of Texas and with which any other Blue Cross and Blue Shield plan has executed such a written contract

to provide health care services to Participants covered under the Policy. Except as otherwise provided herein, a Network Provider must provide services in order for You to obtain Network Benefits.

**An Out-of-Network Provider is**:

- Any Provider who has not executed a managed care agreement with BCBSTX; or
- Any other Provider located outside the state of Texas and with which any other Blue Cross and Blue Shield plan has not executed such a written contract to provide health care services to Participants covered under the Policy. Except as otherwise provided herein, services provided by Out-of-Network Providers will receive Out-of-Network Benefits.

In addition, Providers who do not contract with BCBSTX or any other Blue Cross and Blue Shield plan may bill the patient for expenses above the Allowable Amount.

If You receive covered services from an Out-of-Network Provider because the services are not reasonably available through a Network Provider in the Network Service Area or as otherwise specified by applicable law or regulation, the Out-of-Network Provider will be reimbursed by BCBSTX at the same Coinsurance percentage of reimbursement as a Network Provider would have been reimbursed had You been treated by a Network Provider.

## Covered Services and Supplies Provided by the Policy

This Policy is designed to provide You with coverage for major hospital, medical, and surgical expenses that You incur for Medically Necessary treatment and services rendered as the result of a covered injury or Sickness.

Your Benefit Period is a Calendar Year (begins January 1 and ends December 31).

There may be special cost-sharing rules if you are a Native American. Please contact Customer Service at the toll-free number on your Identification Card or see the Additional Information attached to the Policy.

Coverage is provided for the benefits outlined in this section. The benefits described in this section may be limited by the Limitations and Exclusions.

| **Covered Services** | **Network Benefits**<br>*Individual / Family* | **Out-of-Network Benefits**<br>*Individual / Family* |
|---|---|---|
| **Calendar Year Deductibles** | $500 / $1,500 | $1,000 / $3,000 |
| **Inpatient Hospital Deductible** per Hospital Admission | $250 | $350 |
| **Copayment Amounts** | | |
| Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians. | $40 Primary Care Copayment Amount | 100% of Allowable Amount after the Calendar Year Deductible |
| Specialty Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider. | $70 Specialty Copayment Amount | 100% of Allowable Amount after the Calendar Year Deductible |

| Covered Services | Network Benefits<br>*Individual / Family* | Out-of-Network Benefits<br>*Individual / Family* |
|---|---|---|
| Outpatient surgery Copayment Amount (facility charges only) | $200 Copayment Amount | $300 Copayment Amount |
| Outpatient Hospital emergency room/treatment room visit | $500 Copayment Amount | $500 Copayment Amount |
| **Out-of-Pocket Limit**<br>When a Participant's cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred during a Calendar Year equals the amounts shown below, the benefit percentages change to 100% for the remainder of that Calendar Year. | $500 / $1,500 | $1,000/ $3,000 |
| **Hospital Services**<br>All usual Hospital services and supplies, including semiprivate room, intensive care and coronary care units. If You stay in a private room, only the Hospital's average semi-private room rate will be considered for benefits. | 100% of Allowable Amount after $250 Inpatient Hospital Deductible and after Calendar Year Deductible | 100% of Allowable Amount after $350 Inpatient Hospital Deductible and after Calendar Year Deductible |
| **Professional Services**<br>Services of Physicians or Professional Other Providers, a certified registered nurse-anesthetist, diagnostic x-ray and lab, radiation therapy, maternity care, rental of durable medical equipment, anesthetics, oxygen, blood, Prosthetic Appliances, Orthotic Devices, orthopedic braces and crutches, Home Infusion Therapy services, Diabetic Equipment and Supplies, outpatient contraceptive services and contraceptive devices, and outpatient services and supplies, outpatient surgery, telehealth services and telemedicine medical services. ***Note: prescription contraceptive medications are covered under Your Pharmacy Benefits.*** | 100% of Allowable Amount after the Calendar Year Deductible | 100% of Allowable Amount after the Calendar Year Deductible |
| **Physical Medicine Services** | 100% of Allowable Amount after the Calendar Year Deductible | 100% of Allowable Amount after the Calendar Year Deductible |
| ▪ Habilitative & Rehabilitative therapies | 70 combined visits per Calendar Year | |
| ▪ Chiropractic therapies | 35 visits per Calendar Year<br>Benefits used in Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year maximum amounts indicated | |
| **Extended Care Expense**.<br>Services will require preauthorization | 100% of Allowable Amount after the Calendar Year Deductible | 100% of Allowable Amount after the Calendar Year Deductible |
| ▪ Skilled Nursing Facility<br>▪ Home Health Care<br>▪ Hospice Care | 25 days per Calendar Year<br>60 visits per Calendar Year<br>Unlimited<br>Benefits used in Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year maximum amounts indicated | |

| Covered Services | Network Benefits<br>*Individual / Family* | Out-of-Network Benefits<br>*Individual / Family* |
|---|---|---|
| **Emergency Services**<br><br>**Accident & Medical Emergency**<br>▪ Facility Charges | 100% of Allowable Amount after $500 Outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible | |
| ▪ Physician Charges | 100% of Allowable Amount after Calendar Year Deductible | |
| **Non-Emergency Situations**<br><br>▪ Facility Charges | 100% of Allowable Amount after $500 Outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible | 100% of Allowable Amount after $500 Outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible |
| ▪ Physician Charges | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |
| **Ambulance Services** | 100% of Allowable Amount<br>after the Calendar Year Deductible | |
| **Urgent Care Services**<br>▪ Urgent Care Provider Charge | $75 Copayment Amount | 100% of Allowable Amount after Calendar Year Deductible*<br><br>*Urgent Care Provider Copayment Amount will apply to Accident & Medical Emergency Services provided Out-of-Network |
| ▪ All other services received during an Urgent Care visit | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |
| **Organ and Tissue Transplants**.<br>Services will require preauthorization | 100% of Allowable Amount<br>after the Calendar Year Deductible | 100% of Allowable Amount<br>after the Calendar Year Deductible |
| **Preventive Care**. Benefits will be provided for the following Covered Services (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"); (2) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved; (3) evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and (4) with respect to women, such additional preventive care and screenings, not described in item 1 above, as provided for in comprehensive guidelines supported by the HRSA.<br><br>The Preventive Care Services described in items 1 through 4 above may change as the USPSTF, CDC, and HRSA guidelines are modified. For more | 100% of Allowable Amount | 100% of Allowable Amount<br>after Calendar Year Deductible |

| Covered Services | Network Benefits<br>*Individual / Family* | Out-of-Network Benefits<br>*Individual / Family* |
|---|---|---|
| information You may visit Our website at www.bcbstx.com or call the Customer Service at the telephone number shown on Your Identification Card.<br>Examples of Covered Services included are well child care, routine annual physical, immunizations, routine mammograms, routine bone density test, colorectal cancer screenings, prostate cancer screenings, HPV/cervical cancer screenings, healthy diet counseling, obesity screening/counseling and smoking cessation counseling.<br>Examples of covered immunizations include Hepatitis A, Hepatitis B, Human Papillomavirus, influenza, Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Polio, Rotavirus, Rubella, Tetanus, Varicella, and any other immunization that is required by law. Allergy injections are not considered immunizations under this benefit provision.<br>Covered Services not included in items 1 through 4 above will be subject to Coinsurance Amount, deductible, Copayment Amount or dollar maximum.<br>**Benefits for Outpatient Contraceptive Services** Benefits for Eligible Expenses incurred for Outpatient Contraceptive Services received from a Network Provider will not be subject to Copayment Amounts, Coinsurance Amounts and Deductibles or dollar maximums:<br>Benefits will be provided to women with reproductive capacity for specified drugs and devices in each of the following categories of FDA approved contraceptive drugs and devices, including certain: progestin-only contraceptives; combination contraceptives; emergency contraceptives; extended-cycle/continuous oral contraceptives; cervical caps; diaphragms; implantable contraceptives; intra-uterine devices; injectables; transdermal contraceptives and vaginal contraceptive devices. The contraceptive drugs and devices listed above may change as FDA guidelines, medical management and medical policies are modified. NOTE: Prescription contraceptive medications are covered under the Your Pharmacy Benefits section of the Policy.<br>Contact Customer Service at the toll-free number on your Identification Card to determine what contraceptive drugs and devices are covered under this benefit provision.<br>Contraceptive drugs and devices not covered under this benefit provision may be covered under other sections of this certificate, subject to any applicable Coinsurance Amount, Copayment Amount, Deductibles and/or benefit maximum.<br>Benefits will be provided for female sterilization procedures for women with reproductive capacity and Outpatient Contraceptive Services. Also, benefits will be provided for FDA approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner. The Participant will be | | |

| Covered Services | Network Benefits<br>*Individual / Family* | Out-of-Network Benefits<br>*Individual / Family* |
|---|---|---|
| responsible for submitting a claim form with the written prescription and itemized receipt for the female over-the-counter contraceptive. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.<br>Benefits for the above listed services received from Out-of-Network Providers or non-Participating Pharmacies may be subject to any applicable Deductible, Coinsurance Amount, Copayment Amount and/or benefit maximum.<br>**Benefits for Breastfeeding Support, Services and Supplies** Benefits for Eligible Expenses incurred for Breastfeeding Support, Services and Supplies received from a Network Provider will not be subject to Copayment Amounts, Coinsurance Amounts and Deductibles or dollar maximums.<br>Benefits will be provided for breastfeeding counseling and support services rendered by a Provider during pregnancy and/or in the post-partum period.<br>Benefits will also be provided for the rental (or at Our option, the purchase) of manual, or electric breast pumps or the rental only of a Hospital grade breast pump and supplies. You may be required to pay the full cost for the rental (or purchase) of a manual or electric breast pump or the rental only of a Hospital grade breast pump and supplies and submit a claim form to Us with a written prescription and itemized receipts. Visit the BCBSTX website at www.bcbstx.com for to obtain a claim form.<br>Contact Customer Service at the toll-free number on your Identification Card for additional information on the benefits covered under this provision.<br>If you use an Out-of-Network Provider, the benefits may be subject to any applicable Deductible, Coinsurance Amount, Copayment Amount and/or benefit maximum. | | |
| **Certain Tests for Detection of Human Papillomavirus and Cervical Cancer**<br>Certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman covered under the Policy who is 18 years of age or older. | 100% of Allowable Amount | 100% of Allowable Amount after Calendar Year Deductible |
| **Routine Mammography Screening**<br>A screening by low-dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older. Benefits will not be available for more than one routine mammography screening each Calendar Year. | 100% of Allowable Amount | 100% of Allowable Amount after Calendar Year Deductible |
| **Tests for Detection of Colorectal Cancer**<br>Diagnostic, medically recognized screening examination for the detection of colorectal cancer for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer:<br>▪ A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or | 100% of Allowable Amount | 100% of Allowable Amount after Calendar Year Deductible |

| Covered Services | Network Benefits<br>*Individual / Family* | Out-of-Network Benefits<br>*Individual / Family* |
|---|---|---|
| ▪ A colonoscopy performed every ten years. | | |
| **Certain Tests for Detection of Prostate Cancer**<br>An annual medically recognized diagnostic, physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male covered under the Policy who is at least:<br>▪ 50 years of age and asymptomatic; or<br>40 years of age with a family history of prostate cancer or another prostate cancer risk factor. | 100% of Allowable Amount | 100% of Allowable Amount after Calendar Year Deductible |
| **Childhood Immunizations** *(Does not include allergy injections* (From birth through age 6)<br>Immunizations includes but are not limited to, diphtheria, hemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization required by law. | 100% of Allowable Amount | |
| **Hearing Screening**<br>• Screening tests from birth through the date the child is 30 days old<br>• Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. | 100% of Allowable Amount | 100% of Allowable Amount |
| **Certain Therapies for Children with Developmental Delays** *(up to age 3 as defined in the **individualized family service plan** as issued by the Texas Interagency Council on Early Childhood Intervention.) Such therapies include:*<br>▪ Occupational therapy evaluations<br>▪ Physical therapy evaluations and services<br>▪ Speech therapy evaluations and services; and<br>▪ Dietary or nutritional evaluations<br>After the age of 3, when services under the **individualized family service plan** are completed, Eligible Expenses, as otherwise covered under this Policy, will be available. All contractual provisions of this Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum. | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |
| **Autism Spectrum Disorder** For a covered child from birth but who has not yet reached the age of 10, generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are available.<br>For purposes of this benefit, generally recognized services may include services such as:<br>▪ evaluation and assessment services;<br>▪ applied behavior analysis;<br>▪ occupational therapy;<br>▪ physical therapy;<br>▪ speech therapy; or<br>▪ medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |

| Covered Services | Network Benefits<br>*Individual / Family* | Out-of-Network Benefits<br>*Individual / Family* |
|---|---|---|
| After the age of 10, Eligible Expenses, as otherwise covered under this Policy, will be available. All contractual provisions of this Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum. | | |
| **Behavioral Health Services**<br>***Treatment of Chemical Dependency / Serious Mental Illness / Mental Health Care* — Benefits are available for treatment as follows. Certain services will require preauthorization:** | | |
| **Inpatient Services** | | |
| ▪ Inpatient treatment must be provided in a Mental Health Treatment Center / Chemical Dependency Treatment Center / Hospital services (facility) | 100% of Allowable Amount after $250 Inpatient Hospital Deductible and after Calendar Year Deductible | 100% of Allowable Amount after $350 Inpatient Hospital Deductible and after Calendar Year Deductible |
| ▪ Behavioral Health Practitioner services | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |
| **Outpatient Services** | | |
| ▪ Behavioral Health Practitioner expenses (office setting) | $40 Primary Care Copayment Amount | 100% of Allowable Amount after Calendar Year Deductible |
| ▪ Other outpatient services | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |
| **Routine Annual Adult Eye Exam**<br>Routine adult eye exam ages 19 and over | Covered as any other sickness | Covered as any other sickness |
| **Speech and Hearing** | | |
| Services to restore loss of or correct an impaired speech or hearing function with hearing aids | Covered as any other sickness | Covered as any other sickness |
| Hearing Aids | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |
| Hearing Aids maximum | Limited to two hearing aids every three years<br>Benefits used in Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year maximum amounts indicated | |
| **Early Detection Tests for Cardiovascular Disease**<br>One of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function:<br>(1) Computed tomography (CT) scanning measuring coronary artery calcifications; or<br>(2) Ultrasonography measuring carotid intima-media thickness and plaque. | 100% of Allowable Amount after the Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |
| Tests are available to each Participant who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher. | Benefits are limited to 1 screening every five (5) years each Participant. | |

| Covered Services | Network Benefits<br>*Individual / Family* | Out-of-Network Benefits<br>*Individual / Family* |
|---|---|---|
| **Non-Routine Diagnostic Mammography** | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |
| **Breast Reconstruction** | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |

## Pharmacy Benefits including Mail Order

***Copayment or Coinsurance Amounts***
The Copayment or Coinsurance Amounts for Covered Drugs filled by a Participating Pharmacy, Non-Participating Pharmacy or a mail-order Pharmacy are shown below. If the Allowable Amount of the Covered Drug is less than the Copayment or Coinsurance Amount, the Participant will pay the lower cost.

Injectable drugs for subcutaneous self-administration are also covered by the Policy and are subject to the applicable Copayment or Coinsurance Amount. Injectable drugs include, but are not limited to insulin and Imitrex.

Payment of benefits covered under this Policy may be denied if drugs are dispensed or delivered in a manner intended to change or having the effect of changing or circumventing, the 90-day maximum quantity limitation (for instance, if You obtain multiple refills for the same Prescription Order before the original supply is consumed).

***Member Pays the Difference***
If You obtain a brand name drug when a Generic Drug is available, You will pay the Non-Preferred Brand Name Drug Copayment Amount **plus** the pricing difference between the Generic Drug and the Non-Preferred Brand Name Drug.

| **PHARMACY BENEFITS** | | |
|---|---|---|
| | Participating Pharmacy<br>**Participant pays**… | Non-Participating Pharmacy<br>**Participant pays**… |
| Retail Pharmacy<br>30-Day<br>Supply | No Copayment Amount - preferred Generic Drug<br><br>$10 Copayment Amount – non-preferred Generic Drug<br><br>$50 Copayment Amount – Preferred Brand Name Drug<br><br>$100 Copayment Amount* – Non-Preferred Brand Name Drug | 50% of Allowable Amount ** – preferred Generic Drug<br><br>50% of Allowable Amount ** – non-preferred Generic Drug<br><br>50% of Allowable Amount ** – Preferred Brand Name Drug<br><br>50% of Allowable Amount ** - Non-Preferred Brand Name Drug |
| Retail Pharmacy<br>Extended Supply ***<br><br>One Copayment Amount per 30-day supply, up to a 90-day supply | No Copayment Amount - preferred Generic Drug<br><br>$10 Copayment Amount – non-preferred Generic Drug<br><br>$50 Copayment Amount* – Preferred Brand Name Drug<br><br>$100 Copayment Amount – Non-Preferred Brand Name Drug | 50% of Allowable Amount ** – preferred Generic Drug<br><br>50% of Allowable Amount ** – non-preferred Generic Drug<br><br>50% of Allowable Amount ** – Preferred Brand Name Drug<br><br>50% of Allowable Amount ** - Non-Preferred Brand Name Drug |
| Mail Service<br>90-Day Supply | No Copayment Amount – preferred Generic Drug<br><br>$20 Copayment Amount – non-preferred Generic Drug<br><br>$100 Copayment Amount – Preferred Brand Name Drug | |

| PHARMACY BENEFITS | | |
|---|---|---|
| | $200 Copayment Amount* – Non-Preferred Brand Name Drug | |
| | Specialty Pharmacy<br>**Participant pays**… | Other Pharmacy<br>**Participant pays**… |
| Specialty Drugs<br>30-Day Supply | $150 Copayment Amount - Specialty Drug | 50% of Allowable Amount ** - Specialty Drug |
| | Select Participating Pharmacies<br>**Participant pays**… | Non-Participating Pharmacy<br>**Participant pays**… |
| Vaccinations obtained through Pharmacies**** | No Copayment Amount | 50% of Allowable Amount** |

* If you receive a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Your Pharmacy Benefits section of your Policy for details.

** Plus the appropriate Calendar Year Deductible plus any applicable Copayment Amount or Coinsurance Amount and any applicable pricing differences.

*** If allowed by Prescription Order

**** Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so You are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical benefits available for childhood immunizations.

To get the most out of Your coverage, it is important that You carefully read the **Your Pharmacy Benefits** and **Limitations and Exclusions** sections of the Policy so You are aware of Policy requirements, provisions, limitations and exclusions. There are provisions concerning Quantity Limits, Preauthorization and Specialty Drugs.

## Emergency Services

**Emergency Services** means health care services provided in a Hospital emergency facility, freestanding emergency medical care facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the patient's health in serious jeopardy,
- Serious impairment to bodily functions,
- Serious dysfunction of any bodily organ or part,
- Serious disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

In the event of an emergency, you should do one of the following:

- If reasonably possible, contact your Network Provider before going to the Hospital emergency room. He can help you determine if you need Emergency Services and recommend that care.
- If not reasonably possible to contact your Network Provider, go to the nearest emergency facility, whether or not the facility is a Network Provider.
- Whether you require hospitalization or not, you should contact your Network Provider within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.
- If hospitalization for an Emergency Medical Condition is necessary, the admission must be preauthorized within two working days, or as soon as reasonably possible, following the admission.

## Out-of-Area Services and Benefits

Except for Emergency Services treatment or covered services that are not available from a Network Provider within the Plan Service Area, benefits will be provided at the Out-of-Network Benefits level. Additionally, the Allowable Amount for Out-of-Network Emergency Care and care provided by an Out-of-Network Provider when a Network Provider is not reasonably available to an insured will be no less than the amount required by Texas law and regulations.

## What Are My Financial Responsibilities?

You are entitled to coverage under the Policy provided the required premium is paid to BCBSTX. In addition to the payment of premiums, You are also responsible for the following:

- If you choose Network Providers, Your payment obligation will be any Deductibles, Copayment Amounts and Coinsurance Amounts, and any limited or noncovered services as described in the Policy.
- If You choose Out-of-Network Providers, You will be responsible for billed charges above BCBSTX payment amount, preauthorization penalties, Deductibles, Coinsurance Amounts and any limited or noncovered services as described in the Policy.

## Limitations and Exclusions

***Benefits under the Medical portion of the Policy are not available for:***

- Services or supplies not Medically Necessary for the treatment of a Sickness, injury, condition, disease, or bodily malfunction; any Experimental/Investigational services and supplies.
- Any charges more than the Allowable Amount as determined by Us.
- Any services and supplies for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law; or any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or any laws, regulations or established procedures of any county or municipality, except as provided in the **State Government Programs** provision in the **General Provisions** section of the Policy . This exclusion shall not be applicable to any legislation, which specifies that the benefits of the Policy shall be deducted from the benefits available under such legislation.
- Services or supplies for which You are not required to make payment or for which You are not legally required to pay without this or any similar coverage, (**except** treatment of mental illness or mental retardation by a tax supported institution).
- Any services or supplies provided by a person who is related to You by blood or marriage, except a Doctor of Dentistry.
- Treatment of injury or Sickness because of war, acts of war, or while on active or reserve military duty.
- Charges resulting from failure to keep a scheduled visit with a Physician or Professional Other Provider, for completion of any insurance forms, or for acquisition of medical records unless requested and received by Us.
- Room and board charges during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been done on an outpatient basis.
- Services or supplies provided during a Hospital Admission or an admission in a Facility Other Provider beginning before the patient's Effective Date, or services or supplies provided after the termination of the Participant's coverage, **except** as provided in the Policy.
- Dietary and nutritional services, **except** as may be provided in the Policy for (1) a nutritional assessment program provided in and by a Hospital and approved in advance by Us; (2) ***Treatment of Diabetes***; (3) ***Certain Therapies for Children with Developmental Delay and (4) Autism Spectrum Disorder***.
- Custodial Care.
- Routine physical examinations, unless specifically stated in the policy.
- Services or supplies (**except** Medically Necessary diagnostic and/or surgical procedures) for treatment of the jaw bone joints, muscles, or their related structures with appliances or splints, physical therapy, or alteration to eliminate pain or dysfunction.
- Services or supplies provided to correct congenital, developmental or acquired deformities of the jaw bone after a Participant's 19th birthday.

- Any items of *Medical-Surgical Expense* provided for dental care and treatments, dental surgery, or dental appliances, **except** (1) Oral Surgery as defined in the Policy, (2) congenital defects of a covered child, or (3) services made necessary by Accidental Injury.
- Cosmetic, Reconstructive or Plastic Surgery unless caused by injury, congenital defects of a covered child, reconstructive surgery following cancer surgery; reconstructive surgery following mastectomy; surgery and reconstruction of the other breast to achieve symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.
- Any services or supplies, except for benefits provided by Pediatric Vision Care Benefits attached to this Policy, provided for: 1)Treatment of myopia and other errors of refraction, including refractive surgery; or 2) Orthoptics or visual training; or 3) Eyeglasses, contact lenses or hearing aids, provided that intraocular lenses and cochlear implant devices shall be specific exceptions to this exclusion and **except** as may be provided for in the **Special Benefit Provisions** section in the **Your Medical Benefits** of the Policy; or 4) Examinations for the prescription or fitting of eyeglasses, contact lenses or hearing aids, **except** as may be provided for in the **Special Benefit Provisions** section in the **Your Medical Benefits** of the Policy.
- Private duty nursing services, except for covered ***Extended Care Expense***.
- Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the ***Benefits for Autism Spectrum Disorder*** provision and the ***Benefits for Physical Medicine Services*** provision in the **Special Benefit Provisions** of the Policy.
- Travel, whether recommended by a Physician or Professional Other Provider, **except** Ambulance Services as provided in the Policy.
- Treatment of obesity or weight, including surgical procedures, even if other health conditions might be helped by the reduction. This exclusion does not apply to healthy diet counseling or obesity screening/counseling.
- Any services or supplies for inpatient allergy testing, or any testing or treatment for environmental sensitivity or clinical ecology, or any treatment not recognized as safe and effective.
- Any services or supplies provided with chelation therapy **except** treatment of acute metal poisoning.
- Any services or supplies for sterilization reversal (male or female), transsexual surgery, sexual dysfunction, in vitro fertilization services, or artificial insemination.
- Routine foot care, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency, as described in the Policy.
- Any Speech and Hearing Services **except** as provided in the Policy for (1) ***Extended Care Expense***, (2) ***Preventive Care***, (3) ***Newborn Screening Tests for Hearing Impairment,*** (4) ***Certain Therapies for Children with Developmental Delay,*** (5) ***Autism Spectrum Disorder*** and (6) ***Speech and Hearing Services***.
- Any services or supplies for reduction mammoplasty.
- Services or supplies for acupuncture, videofluoroscopy, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
- Orthodontic or other dental appliances; splints or bandages provided by a Physician in a non-hospital setting or purchased "over-the-counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts, **except** for podiatric appliances when provided in conjunction with treatment of diabetes.
- Services or supplies provided for or in conjunction with conditions, which have been specifically excluded for a Participant.
- Any drugs and medicines, **except as may be** provided under the **Pharmacy Benefits** section of the Policy, that are: (1) dispensed by a Pharmacy and received by the Participant while covered under the Policy, (2) injected, ingested or applied in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by the Participant for use on an outpatient basis, (3) over-the-counter drugs and medicines; or drugs for which no charge is made, (4) prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, or (5) Retin-A or pharmacological similar topical drugs.
- Any male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide, when not prescribed by a Health Care Practitioner.
- Any services, supplies or drugs received by a Participant outside of the United States, except for Emergency Services.
- Any services or supplies not specifically defined as Eligible Expenses in the Policy.

***The benefits provided under the Pharmacy Benefits are not available for:***

- Drugs which are not included on the Drug List.
- Drugs which do not by law require a Prescription Order, **except** as indicated under Preventive Care in **Your Pharmacy Benefits** section of the Policy, from a Provider or authorized Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through Pharmacies as shown on Your Schedule of Coverage); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.
- Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraceptive devices and the rental or at Our option, the purchase of a manual or electric breast pump are provided under the Your Medical Benefits section of the Policy.
- Administration or injection of any drugs.
- Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative or as indicated under Preventive Care in **Your Pharmacy Benefits** section of the Policy).
- Drugs injected, ingested or applied in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this item shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.**.**
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Coinsurance Amount and/or Copayment Amount provided under the Policy.
- Infertility medications and fertility medications; prescription contraceptive devices, non-prescription contraceptive materials (**except** prescription contraceptive medications which are Legend Drugs. However, coverage for prescription contraceptive devices is provided under the medical portion of the Policy.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Specialty Drugs, unless obtained through the *Specialty Pharmacy Program*
- Any male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide, when not prescribed by a Health Care Practitioner.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA).
- Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting; drugs given through routes other than subcutaneously in the home setting. This exception does not apply to dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. This exception also does not apply to amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins, severe food protein-induced enterocolitis syndromes, eosinophilic disorders, as evidenced by the results of biopsy and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. A Prescription Order from your Health Care Practitioner is required.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.

- Drugs, the use or intended use of, which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, Sickness, disease, injury, or bodily malfunction which is not covered under the Program, or for which benefits have been exhausted.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) , in the same strength, unless otherwise determined by BCBSTX.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
- Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a Prescription Order. (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.) .
- Some equivalent drugs are manufactured under multiple brand-names. In such cases, BCBSTX may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this Plan, the brand name drug purchases will not be covered under any benefit level. A list of brand or generic medications with lower cost therapeutic alternatives may exist.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Prescription drugs required for international travel or work.
- Drugs which are repackaged by a company other than the original manufacturer.

## Preauthorization Requirements

Preauthorization is required for all Hospital Admissions, *Extended Care Expense* and Home Infusion Therapy, organ and tissue transplants and certain Behavioral Health Services. Network Providers will preauthorize services for you when required. If you choose Out-of-Network Providers, You, Your Physician or Professional Other Provider or a family member must call the toll-free telephone number shown on the back of the Identification Card.

When a Hospital Admission is preauthorized, a length-of-stay is assigned. The Policy provides a minimum length-of-stay in a Hospital for the following:

Maternity Care
- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by Caesarean section.

Treatment of Breast Cancer
- 48 hours following a mastectomy
- 24 hours following a lymph node dissection.

If preauthorization is not obtained:

- BCBSTX will review the medical necessity or Experimental/Investigational nature of the treatment prior to final benefit determination.
- Benefits may be reduced or denied if it is determined that the treatment is not Medically Necessary or is Experimental/Investigational.
- You will be responsible for a
  - \$250 penalty for Hospital Admissions, organ and tissue transplants and certain Behavioral Health Services.

– Penalty in the amount of 50% of the Allowable Amount up to a maximum of $250 for Skilled Nursing Facility services, Home Health Care and Hospice Care or Home Infusion Therapy.

## What If My Network Provider's Policy Terminates?

In the event You are under the care of a Network Provider at the time Your Provider stops participating in the Network and at the time of the Network Provider's termination, You are currently being treated for a *special circumstances* such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) are past the 24th week of pregnancy and are receiving treatment in accordance with the dictates of medical prudence, BCBSTX will continue providing coverage for that Provider's services at the Network Benefit level.

*Special circumstances* means a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to You. *Special circumstances* shall be identified by the treating Physician or health care Provider, who must request that the Participant be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from the Participant of any amounts for which the Participant would not be responsible if the Physician or Provider were still a Network Provider.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Participant has been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, for Participants past the 24th week of pregnancy at the time the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

## What If I Have a Complaint?

BCBSTX has established policies and procedures for you to express your dissatisfaction regarding partial or total denial of a claim. You have the opportunity through the complaint, appeal, and grievance processes to request a review of the reimbursement. This process is considered your right. Thus, any retaliatory actions are prohibited by BCBSTX against You or a Provider.

## How Do I Locate Network Providers?

Your Network is the Blue Choice PPO℠ Network. A current list of Network Providers and a complete description of the preferred provider network, including names and locations of Physicians and health care Providers, and a disclosure of which Network Providers will not accept new patients is included in the Preferred Provider Directory. To get a current directory or inquire about a Network Provider, call the Customer Service telephone number shown on the back of Your Identification Card or You may visit Our website at www.bcbstx.com. An updated directory will be available at least annually.

You may also call the BCBSTX Customer Service Helpline at: **1-888-697-0683 toll free** or You may visit Our web site at www.bcbstx.com to:

- Identify Your Network Service Area
- Receive information about Network Providers
- Assist You in identifying a Preferred Provider (but specific Network Providers will not be recommended).

## Plan Service Area

Your Network Service Area is statewide.

## Renewability

The Policy is Guaranteed Renewable.

A. If Your coverage in a QHP is terminated for any reason, BCBSTX will provide You with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage. BCBSTX will also notify the Exchange of the termination effective date and the reason for termination.

Your and your Dependents' coverage will be terminated due to the following events and will end on the dates specified below:

Termination in a Qualified Health Plan

- You terminate your coverage in a Policy, including as a result of Your obtaining other Minimum Essential Coverage, with reasonable, appropriate notice to the Exchange and BCBSTX. For the purposes of this section, reasonable notice is defined as 14 days from the requested effective date of termination; or
- The last day of coverage will be:
  - The termination date specified by You, if You provide reasonable written notice; or
  - 14 days after the termination is requested by You, if You do not provide reasonable notice; or
  - On a date determined by BCBSTX, if BCBSTX is able to effectuate termination in fewer than 14 days and you request an earlier termination effective date; or
- When You are no longer eligible for QHP coverage through the Exchange The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange unless You request and earlier termination effective date; or
- The QHP terminates or is decertified; or
- You change from one QHP to another during an annual open enrollment period or special enrollment period. The last day of coverage in your prior QHP is the day before the effective date of coverage in your new QHP.

Termination by BCBSTX

- When BCBSTX does not receive the full premium payment on time or when there is a bank draft failure of premiums subject to the Grace Period provided in the **General Provisions** section of the Policy; or
- On the Policy Date for fraudulent or intentional misrepresentation of a material fact that results in Rescission of the Policy; or
- On the date of death of the Subscriber; or
- On the date You no longer reside, live or work in the area where BCBSTX is authorized to do business. You may call Customer Service at the number shown on the back of Your Identification Card to determine if You are in this area or You may visit Our website at www.bcbstx.com.

B. We have the right to cancel the Policy after 90 days notice to You but only if all Policies of this particular type of individual coverage are being canceled provided We act uniformly without regard to any Health-Status Related Factor of covered individuals and each Participant shall have the option to purchase on a guaranteed issue basis any other individual health insurance policy We offer at the time of discontinuance of the Policy.

C. If We cancel the Policy as stated in Section B, above, a Participant does not elect to purchase another hospital, medical or surgical policy, and if he is totally disabled on the cancellation date as described in Section B, above, coverage continues and shall be limited to: (1) the duration of the Benefit Period; (2) payment of maximum Policy benefits; or (3) a period not less than 90 days.

D. If We cancel the Policy as stated in Section B above, and a Participant does not elect to purchase another hospital, medical or surgical policy, an extension of benefits shall be provided for any pregnancy of a Participant which commenced while this Policy was in force and for which benefits would have been payable had the Policy continued in force.

E. We may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if We:

- Notify the Texas Department of Insurance Commissioner not later than 180 days prior to the date coverage under the first individual hospital, medical or surgical health benefit plan terminates;
- Notify each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and

- Act uniformly without regard to any Health-Status Related Factor of covered individuals or Dependents of covered individuals who may become eligible for coverage.

In the event that there is a conflict between **Termination in a Qualified Health Plan** and **Termination by BCBSTX**, the provision that is most favorable to the Member will apply

## Premiums

Premiums are due on the first day of each Policy Month.

A. The premium rates for the Policy are established based on a number of factors such as the age of the Subscriber, place of residence, tobacco use, and the number covered under the Policy. We have the right to increase premiums after 60 days notice to You. Your premium will not be adjusted more often than annually except for:

1. in connection with changes to or as otherwise expressly permitted by state or federal laws and regulations; or
2. changes to coverage classification (for example, to a new age category or geographic location, tobacco use, or from a single family member coverage to a two family member coverage type), or
3. as otherwise permitted by the Policy.

No eligibility rules or variations in premiums will be imposed based on Your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or another health status-related factor.

If both husband and wife are included on the same membership, the Subscriber's premium will be based on the age of each adult.

B. Except as provided below, a Grace Period is provided for each premium payment. A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the Policy shall continue in force. After a Grace Period of 31 days, coverage under the Policy will automatically terminate on the last day of the coverage period for which premiums have been paid.

In the event you are receiving an Advance Premium Tax Credit under the Affordable Care Act, You have a three-month Grace Period for paying premiums. If full premium is not paid within one month of the premium due date, claim payments for Eligible Expenses received during the second and third months of the Grace Period under the Policy will be pended until full premium payment is made. If full payment of the premium is not made within the three months Grace Period, then coverage under the Policy will automatically terminate on the last day of the first month of the three-month grace period. BCBSTX will not process any claims for services after the date of termination, except as otherwise required by applicable state or federal law.

**IMPORTANT TO YOUR COVERAGE**

**To pay less out-of-pocket expenses and to receive the higher level of benefits for your health care costs, it is to your advantage to use Network Providers. If you use Network Providers, you will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much you would pay if you use a Network Provider and how much you would pay if you use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same. (NOTE: In most cases, however, the non-contracting Allowable Amount will be less than the contracting Allowable Amount, meaning your total payment responsibility will be even greater.)**

**EXAMPLE ONLY**

| | **Network**<br>80% of eligible charges<br>$500 Deductible | **Out-of-Network**<br>60% of eligible charges<br>$1,000 Deductible |
|---|---|---|
| Amount Billed | $20,000 | $20,000 |
| Allowable Amount | $5,000 | $5,000 |
| Deductible Amount | $500 | $1,000 |
| Plan's Coinsurance Amount | $3,600 | $2,400 |
| Your Coinsurance Amount | $900 | $1,600 |
| Non-Contracting Provider's additional charge to you | None | $15,000[1] |
| **YOUR TOTAL PAYMENT** | **$1,400**<br>**to a Network Provider** | **$17,600**<br>**to a Non-contracting Out-of-Network Provider** |

**Even when you consult a Network Provider, ask questions about any of the Providers rendering care to you. If you are scheduled for surgery, for example, ensure that your Network surgeon will be using a Network facility for your procedure and a Network Provider for your anesthesia services.**

**[1] If you choose to receive services from an Out-of-Network Provider, inquire if he participates in a contractual arrangement with BCBSTX. Providers who do not contract with BCBSTX or any other Blue Cross and Blue Shield plan will bill the patient for expenses over the Allowable Amount. Please refer to the section entitled *PARPLAN* in the Contract.**

## Texas Department of Insurance Notice

- You have the right to an adequate network of preferred providers (also known as "network providers").
    - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
    - If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

- You have the right, in most cases, to obtain estimates in advance:
    - from out-of-network providers of what they will change for their services; and
    - from your insurer of what it will pay for the services.

- You may obtain a current directory of preferred providers at the following website: **www.bcbstx.com** or by calling the Customer Service number on the back of your ID card for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

- If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.